| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 009443 | A. BUILDING: _____ B. WING _____ | 10/29/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SELECT SPECIALTY HOSPITAL-EVANSVILLE | 400 SE 4TH ST EVANSVILLE, IN 47713 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for the State investigation of a complaint.<br><br>Complaint #IN00175728<br>Substantiated; no deficiencies related to the allegations are cited.<br><br>Facility #: 009443<br><br>Select Specialty Hospital-Evansville is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services., Hospital Licensure Rules.<br><br>QA: cjl 12/07/15 | S 000 | | |